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PATIENT SATISFACTION IN ADJACENT FAMILY PRACTICE AND NON-FAMILY PRACTICE NAVY OUTPATIENT CLINICS

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Patient Satisfaction in Adjacent Family Practice and Non-Family Practice Navy Outpatient Clinics

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Summary

Patient satisfaction was assessed in adjacent family practice (N = 341) and non-family practice (N = 390) clinics at a Naval Regional Medical Center. Results indicated that patients in the family practice clinic were significantly more satisfied with care than those in the non-family practice clinic. Although older people and males were generally more satisfied with care, demographic factors did not differentially affect patient preferences for the family practice approach to ambulatory care.

Patient Satisfaction in Adjacent Family Practice
And Non-Family Practice Navy Outpatient Clinics

Interest in patient satisfaction is based largely on the changing roles of the patient in the health care system. This change from passive to more active patient roles has been precipitated by increasing bureaucracy within the health industry and by general sociopolitical movements toward human rights, self-care, and individual responsibility. As van den Heuvel[1] points out, the recent emergence of a business-bureaucratic approach to health care promotes the economic concepts of supply and demand and recasts the patient into a more active role as a consumer in the health industry.

The patient's role in the health care process has also been affected by the growth of consumerism as a general social movement. The heightened levels of awareness which emanated from the turbulence of the sixties and early seventies played a key role in increasing consumer involvement in all walks of life. In recent years consumer involvement in health services planning, organization, and delivery has been stressed vigorously by the World Health Organization[2] and has gained increasing acceptance among health care planners and providers.[3]

Interest in patient satisfaction has further been advanced by the realization that satisfaction is a potentially important factor in health behaviors such as seeking medical care, complying with medical regimens, and continuing a relationship with a physician.[4] Dissatisfaction with the art of care, on the other hand, tends to be a significant determinant of cancer patients' rejection of the medical establishment in search of emotional support[5] and the instigation of malpractice suits.[6] In addition, measures of patient satisfaction have been useful in evaluating quality of care and in identifying actions to improve services.[7,8]

As patient satisfaction has become accepted as a standard component of evaluative research, interest has focused on making the organization and delivery of health care responsive to consumer opinion. Family practice represents an organizational approach to primary care which emphasizes many factors which are generally related to patient satisfaction. In the family practice model, for example, the physician assumes full responsibility for the continuous and comprehensive health care of the members or families in his (her) practice.[9] Continuity of care has been valued on the grounds that seeing one's own physician is conducive to in-depth understanding of the patient by the practitioner, concomitant patient trust and compliance, and high quality care.[10] A number of studies have reported positive relationships between continuity of care and patient satisfaction.[11-13]

The establishment of a continuing patient-physician relationship also affords the family practice physician an opportunity to provide health and psychological counseling and individualized preventive medicine. This more comprehensive and holistic approach increases the affective support to the patient and facilitates communication within the physician-patient relationship. Because these factors have been established as important determinants of patient satisfaction,[8, 12, 14-17] the family practice approach to primary care may be an effective organizational intervention to enhance consumer satisfaction with ambulatory care.

The purpose of the present study was to compare the levels of patient satisfaction in a family practice and a non-family practice outpatient clinic. A second purpose of this study was to identify demographic factors which may differentially affect patient reactions to family practice vs. non-family practice approaches to primary care. While it was expected that patients in family practice will generally express higher levels of satisfaction than patients in non-family practice, these

differences may be greater among some patient groups than others. The difference between family practice and non-family practice, for example, may be greater among married patients who experience continuity of family care than among those patients who are not married. Similarly, the benefits of family practice may be more strongly manifest among older patients who often require more continuing care or affective support than among younger patients.

Method

Subjects

The sample was comprised of all patients eighteen years of age or older who visited the family practice (N = 341) or primary care clinic (N = 390) of a Naval Regional Medical Center located on a Marine Corps base. Because the families of active duty and retired personnel are typically seen in these base hospital clinics rather than in the smaller active duty field clinics, the majority of the patients in this sample were female (63%). In addition, the patients in the sample were primarily married (88%) and Caucasian (86%). The average age of the sample was 46 years with a standard deviation of 18 years and a range from 18 to 91 years.

Procedure

During a three-week period, patients in the adjacent family practice and non-family practice clinics of the base hospital were asked to complete a two-page questionnaire before leaving the clinic. This questionnaire included a survey of basic demographic information and a 24-item patient satisfaction scale. Based on a review of the patient satisfaction literature, items in this scale were written to measure a number of different aspects of health care delivery. These aspects included access to care, range of services available, care quality, and technical and interpersonal characteristics of the providers. Respondents were asked to indicate their level of satisfaction with each aspect of the health care delivery process on a five-point Likert-type scale. Response choices ranged from "Very dissatisfied" to "Very satisfied." For comparison purposes, responses to each of the 24 items were summed to reflect an overall level of patient satisfaction; higher scores were thus associated with higher levels of satisfaction with services received. Coefficient alpha for the combined items was .961.

Results

The effects of demographic factors (age, sex, marital status) and organization of health care delivery on overall patient satisfaction were analyzed using a four-way analysis of variance. For the purpose of this analysis, subjects were grouped into three age classifications (18-35, 36-50, >50). A hierarchical approach was used such that independent variables were entered into the analysis in the following order: age (3 levels), sex (male, female), marital status (married, not married), and organization of health care delivery (family practice, non-family practice). In this procedure the effects of all preceding independent variables were removed from the analysis of each subsequent main effect and interaction term. Organization of health care delivery was entered as the final independent variable so that all patient demographic effects would be removed from the relationship between organization of health care and patient satisfaction.

The results of this analysis are presented in Table 1. In general, patient satisfaction was significantly related to the age and sex of the patient and to the organization of health care delivery. As shown in Figure 1, older patients were more satisfied with care than younger patients, males were more satisfied than females, and family practice patients were more satisfied than non-family practice

TABLE 1

HIERARCHICAL ANALYSIS OF VARIANCE
OVERALL SATISFACTION

SOURCE OF VARIATION	SUM OF SQUARES	df	MEAN SQUARE	F
	103.513	*5*	*20.703*	*58.810****
AGE	35.483	2	17.742	50.398***
SEX	2.226	1	2.226	6.323**
MARITAL STATUS	0.245	1	0.245	0.695
CLINIC (FP/PC)	65.559	1	65.559	186.233***
	2.539	*9*	*0.282*	*0.801*
AGE X SEX	0.788	2	0.394	1.119
AGE X MARITAL	0.852	2	0.426	1.210
AGE X CLINIC	0.251	2	0.126	0.357
SEX X MARITAL	0.078	1	0.078	0.221
SEX X CLINIC	0.263	1	0.263	0.747
MARITAL X CLINIC	0.029	1	0.029	0.084
	2.260	*7*	*0.323*	*0.917*
AGE X SEX X MARITAL	0.959	2	0.480	1.363
AGE X SEX X CLINIC	0.282	2	0.141	0.401
AGE X MARITAL X CLINIC	0.069	2	0.034	0.098
SEX X MARITAL X CLINIC	0.231	1	0.231	0.657
	0.030	*1*	*0.030*	*0.085*
AGE X SEX X MARITAL X CLINIC	0.030	1	0.030	0.085

$^{***}p < .001$
$^{**}p < .01$

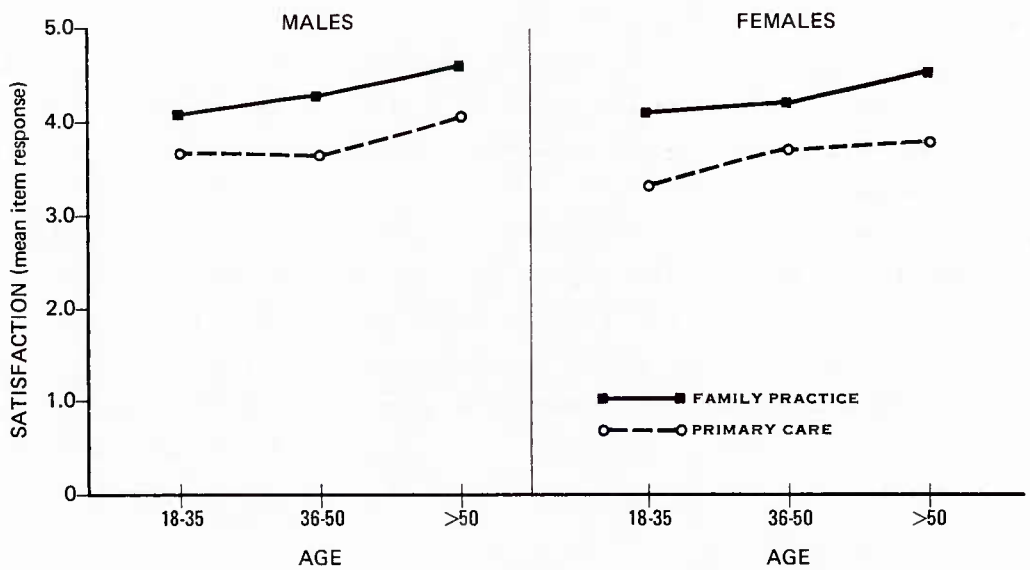

Figure 1. Mean Satisfaction with Family Practice vs. Primary Care (Non-Family Practice) by Sex and Age of Patient.

patients. None of the two-way or higher-order interaction effects was significant.

Discussion

In the present study, levels of patient satisfaction were compared in adjacent family practice and non-family practice clinics. In both clinics results indicated that satisfaction with care was associated with the age and sex of the patient. The finding that older people were generally more satisfied with ambulatory care was consistent with previous studies.[8, 12, 18] Findings regarding the relationship between sex and patient satisfaction, on the other hand, have been less consistent in the literature. While Hulka et al. [19] reported that females were generally more satisfied with all aspects of care, others have reported non-significant sex differences.[11, 16, 20] Pope[12] found no overall sex effect in patient satisfaction; however, he did report that females and individuals higher in education and perceived social class were somewhat more characteristic of those terminating an HMO for reasons of dissatisfaction than other terminees.

In the present study, females were significantly less satisfied than males. While this difference between the sexes was not expected, the following interpretation is considered. In our sample, virtually all of the males (97%) were active duty or retired career military personnel. Very few of the females (2%), on the other hand, had any direct military experience. This difference in military experience may affect patient willingness to express dissatisfaction. Active duty and retired males, for example, may experience higher levels of organizational commitment or cognitive dissonance[21] and be less willing to criticize the health care services. Females, on the other hand, may feel less closely identified with the military system and more willing to express lower levels of satisfaction. This speculation is somewhat consistent with the general finding that when the medical system does not meet their needs, women feel greater freedom to express their displeasure.[19]

The most important finding of the present study was that patients in the family practice program reported significantly higher levels of satisfaction with care than patients in the non-family practice clinic. It is also important to note that organization of health care did not interact significantly with any demographic variable. That is to say, perceived differences in patient satisfaction between the family practice and non-family practice clinics were not significantly affected by the age, sex, or marital status of the patients. In general, all patient groups preferred the family practice approach to ambulatory care.

At present the Navy sponsors residency training programs in family practice at five Naval Regional Medical Centers. While the concept of family practice is fairly new in the Navy, the results of the present investigation indicate that continued growth in this area may strengthen levels of patient satisfaction among both active duty and non-active duty beneficiaries. Further research, however, is required to address the issues of cost effectiveness, program expansion into Naval multispecialty training hospitals,[22] and priority panel allocation to special groups such as families anticipating deployment separation.[23]

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